FY 2008 PERM MEDICAID CORRECTIVE ACTION PLAN EXECUTIVE SUMMARY

This Corrective Action Plan Executive Summary provides an overview of FY 2008 Payment Error Rate Measurement (PERM) findings at the national level and highlights the major causes of error in your state. The PERM corrective action process supports the identification and implementation of cost-effective approaches to reduce error. PERM identifies and classifies types of errors but states must conduct root cause analysis to identify why the errors occur, a necessary precursor to effective corrective action. Thus, your participation is critical during the corrective action phase of the PERM cycle.

Please review the enclosed PERM Findings FY 2008 prepared specifically for your state, as well as the list of year-to-date errors available to you on the SMERF website. We believe PERM is a valuable tool to identify systematic vulnerabilities and inform potential corrective actions. We will work closely with you over the remainder of this cycle to review your error rates, determine the root causes of the errors, and develop corrective actions to address the major causes of error.

A. PERM National Medicaid Findings

The FY 2008 Annual Medicaid Payment Error Rate was released by the Centers for Medicare & Medicaid Services (CMS). The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and produces state and national-level error rates for the program. The error rates are based on reviews of Medicaid payments for the fee-for-service (FFS), managed care, and eligibility components of Medicaid for the 17 states selected for the FY 2008 measurement cycle. The Children's Health Insurance Program (CHIP) was not included in the FY 2008 report due to CHIPRA legislation.[1]

In FY 2008 the overall national Medicaid estimated error rate is 8.71%. All states measured had a Medicaid FFS program, but only 12 had a Medicaid managed care program. The review findings include:

- **The national Medicaid FFS estimated error rate is 2.62%**
- **The national Medicaid managed care estimated error rate is 0.10%.**
- **The national Medicaid eligibility component estimated error rate is 6.74%.**

B. Iowa's Medicaid Findings

In FY 2008 Iowa's Medicaid estimated error rate is 4.91%.

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[1] From the CHIPRA legislation, "The Secretary shall not calculate or publish any national or State-specific error rate based on the application of the payment error rate measurement (in this section referred to as ''PERM'') requirements to CHIP until after the date that is 6 months after the date on which a new final rule (in this section referred to as the ''new final rule'') promulgated after the date of the enactment of this Act and implementing such requirements in accordance with the requirements of subsection (c) is in effect for all States." For this reason, CMS has not calculated nor included the CHIP error rate in this report.

Iowa's review findings include:

- **Iowa's Medicaid FFS estimated error rate is 1.72%**
- **Iowa's Medicaid managed care estimated error rate is 0.00%**
- **Iowa's Medicaid eligibility component estimated error rate is 3.32%.**

C. Summary of Office of Inspector General's Audits

Summarized below are three preliminary audits conducted by the Office of Inspector General (OIG). If any of these audits occurred in your state or seem to be applicable to your state, you should consider including a corrective action which addresses the appropriate OIG audit finding. You can access these reports at the Office of Inspector General's website http://www.oig.hhs.gov/reports.asp. The name of the report and corresponding report number is listed below.

Fee-For-Service Payments for Services Covered by Capitated Medicaid Managed Care (oei-07-05-00320)

The issuance of erroneous fee-for-service Medicaid payments for services covered by capitated Medicaid managed care plans. Medicaid programs should not pay claims for services that are included in capitated Medicaid managed care plans on a fee-for-service basis. Otherwise, Medicaid programs are paying twice for the same service. Manual overrides of automated system edits and faulty system logic appear to be major contributors to claims paid in error.

Payment Made in Error for Personal Care Services during Institutional Stays (oei-07-06-00620)

The Federal Medicaid reimbursement for Personal Care Services (PCS) provided during institutional stays and/or for PCS claims billed with an invalid date range. PCS should never be provided when a claimant is institutionalized nor should PCS claims be billed for days on which no services were provided. A lack of access to or incompleteness of institutional claims data, faulty payment system edits and case manager's failure to terminate service authorizations are likely causes of this issue.

Duplicate Medicaid and Medicare Home Health Payments: Medical Supplies and Therapeutic Services (oei-07-06-00640)

Medicaid and Medicare both paid home health providers for the same medical supplies and/or therapeutic services. Medicaid is the payor of last resort and thus should pay only if Medicare or another payor does not pay for these services. A lack of access to Medicare claims data to see if payment occurred appears to be at the heart of this issue.

Your State was not identified in any of these reports.

D. Next Steps

The corrective action process begins by establishing a corrective action panel consisting of persons within the organization who have decision-making responsibilities that effect policy and procedural change. This panel should review the enclosed PERM Findings FY 2008 prepared specifically for your state, identify programmatic causes of the errors, determine the root causes for the errors, and develop a corrective action plan to address the major causes of these errors.

In analyzing the data, please focus your efforts on major causes of error where you can identify clear patterns. For example, several states have found that particular provider types such as pharmacies or long term care facilities repeatedly fail to comply with documentation requirements, and have determined that a targeted corrective action for these providers is cost-effective and likely to reduce future improper payments. Some states have found it cost-effective to place first priority on errors that are wholly within their control (e.g., pricing and logic errors in the processing system, eligibility errors), then on provider or client errors with clear patterns where education or clarification is likely to result in improvement (e.g., a dozen medical review policy errors due to lack of provider signatures, five pharmacy errors due to missing original scripts), then on idiosyncratic provider errors that can only be addressed through individual provider follow-up and general provider education.

The corrective action plan should include an implementation schedule that identifies major tasks required to implement the corrective action, and timelines including target implementation dates and milestones. Monitoring and evaluation of the corrective action is also essential, to ensure that the corrective action is meeting targets and goals and is achieving the desired results.

CMS will be scheduling a State Forum call to allow states to discuss best practices on how to develop a CAP program. This will be a State led call. Additional details will be forwarded to you as they become available.

CMS appreciates the cooperation extended by Iowa during the FY 2008 measurement and their commitment to safeguarding taxpayers' dollars by ensuring that Medicaid services are rendered and reimbursed accurately. CMS looks forward to continuing our partnership with Iowa during the CAP process.

My aim is to work closely with you to ensure timely submission and implementation of your state's corrective action plan. If you have any questions or concerns do not hesitate to call me at 410-786-8786 or email me at Nicole.Perry@CMS.hhs.gov. You will be notified of the submission due date for the corrective action plan.

I look forward to working with you on developing an effective corrective action plan that will reduce errors and prevent improper payments in the future.

Sincerely,

Nicole Perry

Nicole Perry
PERM CAP State Liaison Officer

CMS/OFM/PCG
Division of Error Rate Measurement

IOWA - PERM Findings FY 2008

Data Analysis for Medicaid Corrective Action Plan

This report provides an overview of FY 2008 Payment Error Rate Measurement (PERM) findings at the national level and then presents data analyses of payment errors in Iowa's PERM sample. The PERM corrective action process supports the identification and implementation of cost-effective approaches to reduce error. PERM identifies and classifies types of errors but states must conduct root cause analysis to identify why the errors occur, a necessary precursor to effective corrective action. Thus, your participation is critical during the corrective action phase of the PERM cycle.

We reviewed the Medicaid claims for fee-for-service (FFS) and managed care. States reviewed eligibility cases. The first two sections of this report include the estimated national and Iowa error rates based on projected payments in error. The remaining sections include sample payments in error. The claim tables include only errors that have dollars in error greater than zero.

E. PERM National Medicaid Findings

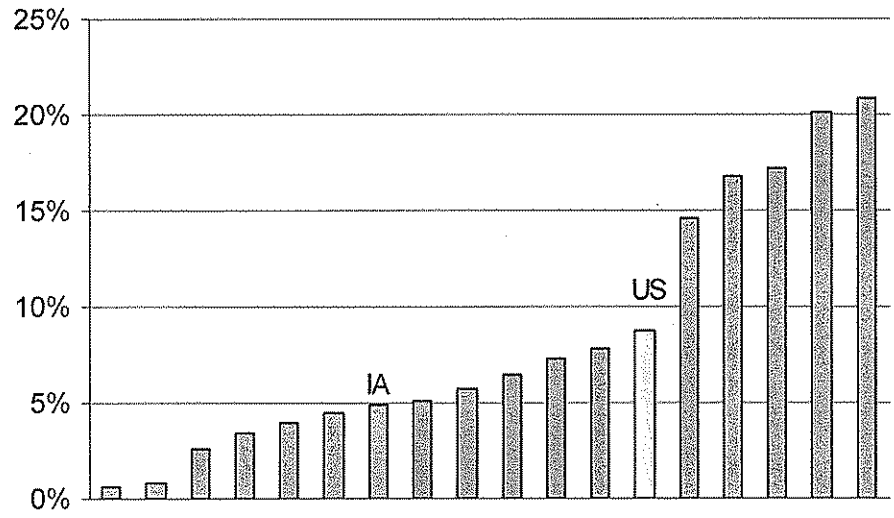
In FY 2008 the overall national Medicaid estimated error rate is 8.71%. All states measured had a Medicaid FFS program, but only 12 had a Medicaid managed care program. The review findings include:

- **The national Medicaid FFS estimated error rate is 2.62%.**
    - For Medicaid FFS medical record reviews, the largest sources of dollars in error are insufficient documentation, no documentation and number of units errors.
    - For Medicaid FFS data processing reviews, the largest sources of dollars in error are non-covered service and administrative/other errors.
    - For Medicaid FFS, the most costly medical review errors by service type are for (1) inpatient hospital, (2) nursing facility, ICF and ICF/MR, and chronic care services; and (3) psychiatric, mental health, and behavioral health services.
- **The national Medicaid managed care estimated error rate is 0.10%.**
    - The largest sources of dollars in error are non-covered service and managed care payment errors.
- **The national Medicaid eligibility component estimated error rate is 6.74%.**
    - The largest sources of dollars in error are not eligible cases, undetermined, and eligible with ineligible services.

F. Iowa's Medicaid Findings

In FY 2008 Iowa's Medicaid estimated error rate is 4.91%. Figure 1 displays Iowa's error rate compared to the national and other FY 2008 states' error rates.

Figure 1 State Error Rate Relative to Other States and the National Error Rate

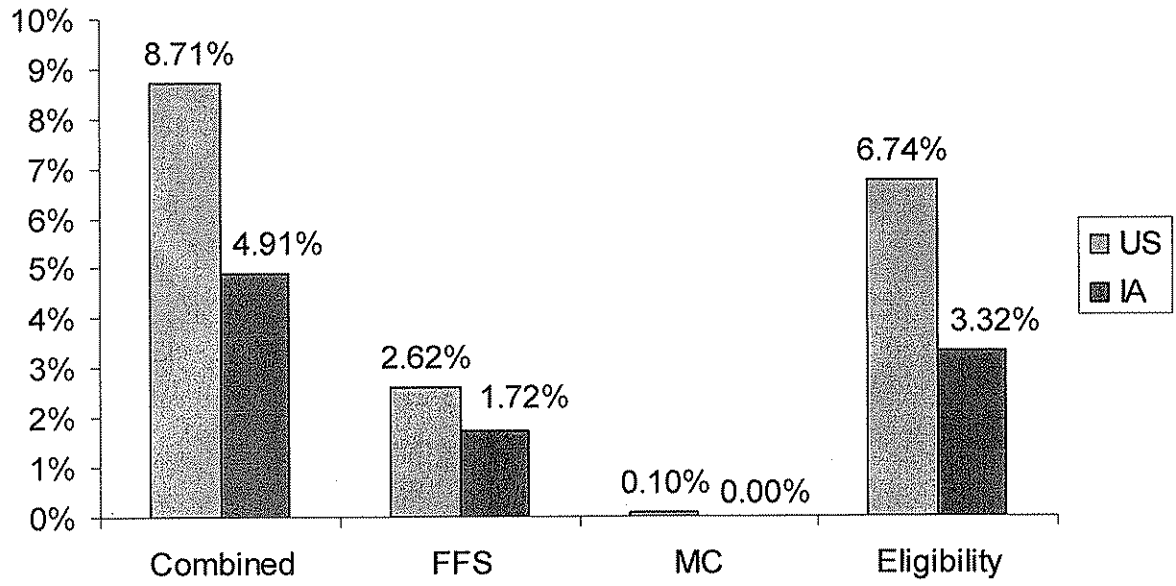


Iowa's review findings include:

- **Iowa's Medicaid FFS estimated error rate is 1.72%**
    - For Medicaid FFS medical record reviews, the largest sources of dollars in error are insufficient documentation and medically unnecessary service errors.
    - For Medicaid FFS data processing reviews, the only source of dollars in error is a pricing error.
    - For Medicaid FFS, the most costly medical review errors by service type are for (1) inpatient hospital services; (2) nursing facility, ICF, ICF/MR, and chronic care services; and (3) hospice services.
- **Iowa's Medicaid managed care estimated error rate is 0.00%**
    - There are no data processing errors, therefore no dollars in error for managed care.
- **Iowa's Medicaid eligibility component estimated error rate is 3.32%.**
    - For the Medicaid eligibility reviews, the largest sources of dollars in error are not eligible and undetermined errors.

Figure 2 compares the nation and Iowa on the combined error rate and the three component error rates.

Figure 2 National and State Combined and Component Error Rates



The remaining analyses in this report are for sample errors and dollars in error. Table 1 summarizes the number and dollars in error for Iowa and the national samples for each component of PERM. Iowa has no Medicaid managed care dollars in error. Please note that because each of the component samples is weighted, the proportion of sample dollars in error will be different than the proportion of the projected payments in error.

Table 1 Medicaid Program Component by State and National Sample Error Payments

Medicaid Program Component	State		National	
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors
Medicaid FFS	8	$12,594.94	362	$909,607.05
Medicaid Managed Care	0	$0.00	31	$2,125.08
Medicaid Eligibility	17	$6,586.33	564	$265,057.90

Table 2 below compares Iowa's errors to the number and dollar value of errors found in the 17-state sample, by error type.

Table 2 National and State Number of Errors and Dollars in Error by Type of Error

	Number of Errors In Sample		Dollar Value of Errors in Sample	
	State	National	State	National
Medical Review Errors				
Insufficient documentation	3	74	$7,838.24	$173,722
Number of unit(s) error	1	32	$80.92	$54,118
Procedure coding error	1	23	$26.19	$45,194
Medically unnecessary service	1	7	$4,556.57	$29,635
Policy violation	1	3	$65.84	$1,101
No documentation	0	66	$0.00	$157,968
Diagnosis coding error	0	9	$0.00	$44,663
Administrative/other	0	3	$0.00	$494
Unbundling	0	1	$0.00	$92
Total	**7**	**218**	**$12,567.76**	**$506,852**
Data Processing Errors				
Pricing error	1	63	$27.18	$16,344
Non-covered service	0	55	$0.00	$161,972
Managed care payment error	0	26	$0.00	$526
Administrative/other	0	22	$0.00	$134,686
Logic edit	0	7	$0.00	$53,328
Data entry error	0	5	$0.00	$14,338
Duplicate item	0	4	$0.00	$30,554
FFS claim for a managed care service	0	3	$0.00	$31,457
Third-party liability	0	2	$0.00	$358
Rate cell error	0	0	$0.00	$0
Total	**1**	**187**	**$27.18**	**$443,563**
Eligibility Errors (Active Cases)				
Not eligible	9	316	$5,464.28	$95,582
Undetermined	5	343	$943.67	$98,443
Liability understated	5	32	$162.28	$15,751
Liability overstated	2	9	$16.10	$3,227
Eligible with ineligible services	0	65	$0	$50,686
Managed care error, ineligible	0	7	$0	$1,213
Managed care error, improperly enrolled	0	3	$0	$156
Total	**21**	**775**	**$6,586.33**	**$265,058**
Eligibility Errors (Negative Cases)				
Improper denial	2	60	N/A	N/A
Improper termination	0	92	N/A	N/A
Total	**2**	**152**	**N/A**	**N/A**

Medicaid FFS Data Analyses

This section provides an analytical description of the reasons for Medicaid FFS payment errors.

Medicaid FFS Medical Review

The top three reasons for Medicaid FFS **medical review errors** in terms of sample dollars in error are:

- Insufficient documentation errors in the amount of $7,838.24,
- Medically unnecessary service error in the amount of $4,556.57, and
- Number of units error in the amount of $80.92.

As can be seen in Figure 3, insufficient documentation accounted for 62.37% of the total medical review dollars in error. The remaining dollars in error are attributed primarily to medically unnecessary service errors.

Figure 3 Medicaid FFS Medical Review Percentage of Dollars in Error by Error Type

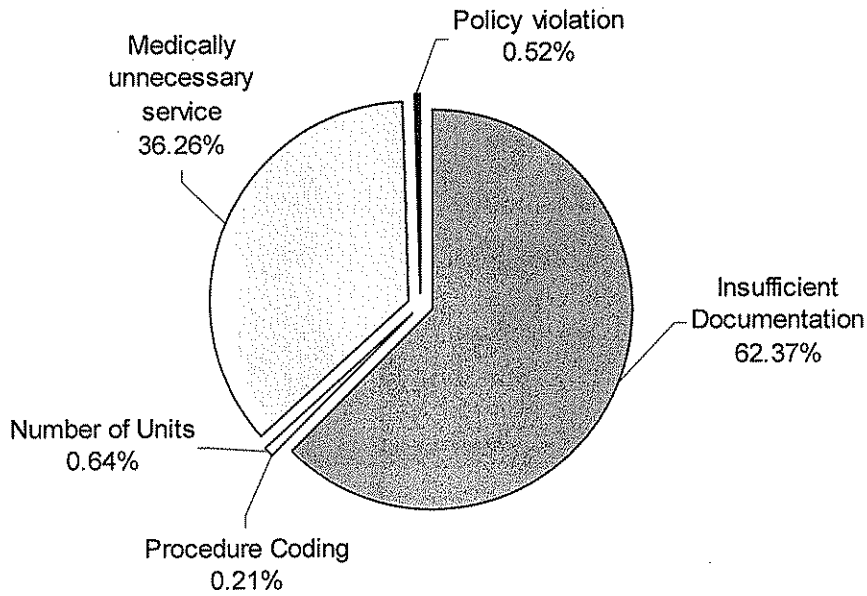


Table 3 has more information regarding the number of medical review errors and dollars in error by overpayments, underpayments, percentage of total error rate and average dollar amount per error. All the medical review errors are overpayments. Medically unnecessary service has the highest average dollar amount per error followed by insufficient documentation.

Table 3 Medicaid FFS Medical Review Error Type by Overpayments, Underpayments, Percentage of Total Error Rate and Average Dollar Amount per Error

Error Type	Overpayments		Underpayments		Percentage of Total Error Rate		Average Dollar Amount Per Error
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors	% of Total Number of Errors	% of Total Dollars in Error	
Insufficient Documentation	3	$7,838.24	0	$0.00	42.86%	62.37%	$2,612.75
Medically Unnecessary Service	1	$4,556.57	0	$0.00	14.29%	36.26%	$4,556.57
Number of Units	1	$80.92	0	$0.00	14.29%	0.64%	$80.92
Policy Violation	1	$65.84	0	$0.00	14.29%	0.52%	$65.84
Procedure Coding	1	$26.19	0	$0.00	14.29%	0.21%	$26.19
Total	**7**	**$12,567.76**	**0**	**$0.00**	**100.00%**	**100.00%**	**$1,795.39**

Common Causes for Medicaid FFS Medical Review Errors by Error Type

Insufficient documentation errors

3 Provider did not supply sufficient documentation to support the claim.

Medically unnecessary service error

1 The patient qualifies for a lower level of care.

Number of units error

1 The incorrect number of units were billed resulting in an overpayment.

Policy violation error

1 The documentation submitted does not contain required signature and/or providers credentials.

Procedure coding errors

1 E/M services documentation has components for a lower level visit.

The percentages of medical review dollars in error by service type are displayed in Figure 4. Inpatient hospital; nursing facility, ICF, ICF/MR, and chronic care; and hospice services are all notable contributors to the total medical review dollars in error.

Figure 4 Medicaid FFS Medical Review Percentage of Dollars in Error by Service Type

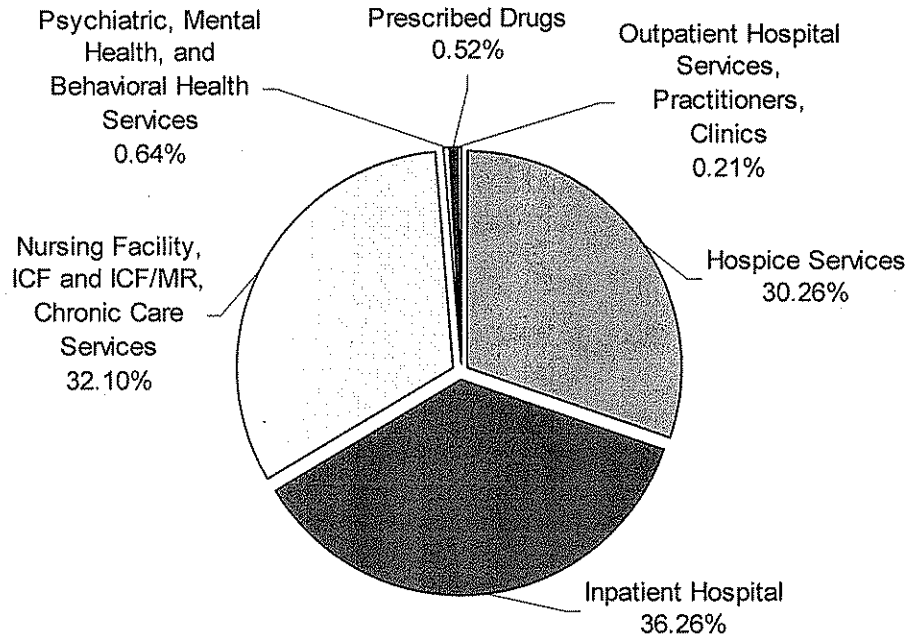


Table 4 has more information regarding the number of medical review errors and dollars in error for service types by overpayments, underpayments, percentage of total error rate, and average dollar amount per error. All of the dollars in error are overpayments. Inpatient hospital services; and nursing facility, ICF, ICF/MR, and chronic care have the highest average dollar amount per error.

Table 4 Medicaid FFS Medical Review Errors by Service Type

Service Type	Overpayments		Underpayments		Percentage of Total Error Rate		Average Dollar Amount Per Error
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors	% of Total Number of Errors	% of Total Dollars in Error	
Inpatient Hospital	1	$4,556.57	0	$0.00	14.29%	36.26%	$4,556.57
Psychiatric, Mental Health, and Behavioral Health Services	1	$80.92	0	$0.00	14.29%	0.64%	$80.92
Nursing Facility, ICF and ICF/MR, Chronic Care Services	1	$4,034.72	0	$0.00	14.29%	32.10%	$4,034.72
Outpatient Hospital Services, Practitioners, Clinics	1	$26.19	0	$0.00	14.29%	0.21%	$26.19
Prescribed Drugs	1	$65.84	0	$0.00	14.29%	0.52%	$65.84
Hospice Services	2	$3,803.52	0	$0.00	28.57%	30.26%	$1,901.76
Total	**7**	**$12,567.76**	**0**	**$0.00**	**100.00%**	**100.00%**	**$1,795.39**

As shown in Table 5, most of the medical review dollars in error are due to insufficient documentation errors for hospice services; and nursing facility, ICF, ICF/MR, and chronic care services; and a medically unnecessary service for inpatient hospital services.

Table 5 Medicaid FFS Service Type by Medical Review Error Type

Service Type	Insufficient Documentation		Medically unnecessary service		Number of Units		Policy violation		Procedure Coding		Total	
	# of Errors	Dollar Amount of Errors	# of Errors	Dollar Amount of Errors	# of Errors	Dollar Amount of Errors	# of Errors	Dollar Amount of Errors	# of Errors	Dollar Amount of Errors	# of Errors	Dollar Amount of Errors
Hospice Services	2	$3,803.52	0	$0.00	0	$0.00	0	$0.00	0	$0.00	2	$3,803.52
Inpatient Hospital	0	$0.00	1	$4,556.57	0	$0.00	0	$0.00	0	$0.00	1	$4,556.57
Nursing Facility, ICF and ICF/MR, Chronic Care Services	1	$4,034.72	0	$0.00	0	$0.00	0	$0.00	0	$0.00	1	$4,034.72
Psychiatric, Mental Health, and Behavioral Health Services	0	$0.00	0	$0.00	1	$80.92	0	$0.00	0	$0.00	1	$80.92
Prescribed Drugs	0	$0.00	0	$0.00	0	$0.00	1	$65.84	0	$0.00	1	$65.84
Outpatient Hospital Services, Practitioners, Clinics	0	$0.00	0	$0.00	0	$0.00	0	$0.00	1	$26.19	1	$26.19
Total	3	$7,838.24	1	$4,556.57	1	$80.92	1	$65.84	1	$26.19	7	$12,567.76

Common Causes for Medicaid FFS Medical Review Errors by Service Type

Hospice Services

2 Insufficient documentation errors

Inpatient Hospital Services

1 Medically unnecessary service error

Nursing Facility, ICF and ICF/MR, Chronic Care Services

1 Insufficient documentation error

Psychiatric, Mental Health, and Behavioral Health Services

1 Number of units error

Prescribed Drugs

1 Policy violation error

Outpatient hospital/physicians/other practitioners/clinics

1 Procedure coding error

Medicaid FFS Data Processing Review

The only reason for Medicaid FFS **data processing review errors** in terms of sample dollars in error is:

- Pricing error in the amount of $27.18.

Table 6 has more information regarding the number of data processing review errors and dollars in error by overpayments, underpayments, percentage of total error rate and average dollar amount per error. There is one data processing review error which is an overpayment.

Table 6 Medicaid FFS Data Processing Review Error Type by Overpayments, Underpayments, Percentage of Total Error Rate and Average Dollar Amount per Error

Error Type	Overpayments		Underpayments		Percentage of Total Error Rate		Average Dollar Amount Per Error
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors	% of Total Number of Errors	% of Total Dollars in Error	
Pricing	1	$27.18	0	$0.00	100.00%	100.00%	$27.18
Total	**1**	**$27.18**	**0**	**$0.00**	**100.00%**	**100.00%**	**$27.18**

Common Causes for Medicaid FFS Data Processing Review Errors by Error Type

Pricing errors

1 System calculation incorrect

The sole data processing error belongs to the outpatient hospital services, practitioners, clinics service type.

Table 7 shows the one pricing error is for outpatient hospital services, practitioners and clinics.

Table 7 Medicaid FFS Service Type by Data Processing Review Error Type

Service Type	Pricing		Total	
	# of Errors	Dollar Amount of Errors	# of Errors	Dollar Amount of Errors
Outpatient Hospital Services, Practitioners, Clinics	1	$27.18	1	$27.18
Total	**1**	**$27.18**	**1**	**$27.18**

Common Causes for Medicaid FFS Data Processing Review Errors by Service Type

Outpatient Hospital Services, Practitioners, Clinics

1 Pricing error

Medicaid Managed Care Data Analyses

There are no data processing errors in the Medicaid managed care sample.

Medicaid Eligibility Data Analyses

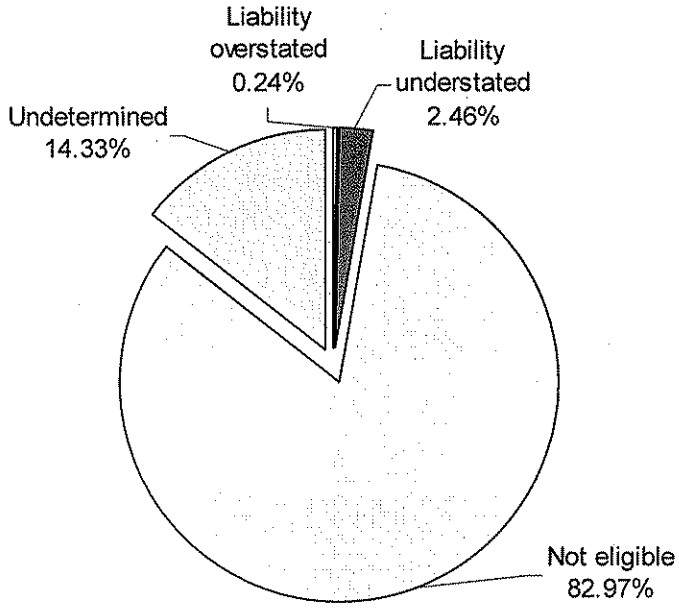
Our eligibility data analysis is limited as each state under the PERM program performed their own eligibility reviews and was only required to report their eligibility and payment findings. The Active Case Review Finding Submission Forms were reviewed to identify the cause for errors reported by the states. The following reasons were the most frequently cited among all states; however, it should be noted that most errors revolve around caseworker errors, misapplication of income and resources policies and lack of internal controls:

- Cases were over the program income limits
- Income was calculated incorrectly in the case record
    - Case workers did not correctly count gross and/or net income, and
    - Case workers included or excluded income incorrectly
- Cases did not meet categorical eligibility criteria for any category of assistance
    - Beneficiary did not meet disability criteria
- Cases exceeded resource limits
- Cases did not meet residency requirements
- Case decisions were inconclusive, or "undetermined" due to insufficient documentation

Some states had a high number of undetermined cases. During interviews several states with fewer undetermined cases mentioned they were able to cut down on the number of undetermined cases by pursuing an aggressive strategy to obtain the required information.

Figure 5 shows the percentage of dollars in error by eligibility review error type for Iowa. Not eligible active cases account for 82.97% of the dollars in error. Undetermined case errors are also notable contributors to the eligibility dollars in error.

Figure 5 Medicaid Eligibility Review Percentages of Dollars in Error by Error Type



Tables 8 and 9 show the Medicaid eligibility review findings for active and negative cases by error type. Almost half of the active case errors are not eligible. For negative cases, all errors are for improper denial.

Table 8 Medicaid Eligibility Errors by Review Finding for Active Cases

Review Finding	Number of Cases	Percentage of Cases
Not eligible	9	42.86%
Liability understated	5	23.81%
Undetermined	5	23.81%
Liability overstated	2	9.52%
Total Active Cases	**21**	**100.00%**

Table 9 Medicaid Eligibility Errors by Review Finding for Negative Cases

Review Finding	Number of Cases	Percentage of Cases
Improper denial	2	100.00%
Total Negative Cases	**2**	**100.00%**

Table 10 shows the number of Medicaid eligibility errors, comparing the number of errors and dollars in error by stratum. The new applications stratum has one-third of the number of errors, but all other active cases account for more than half of the dollars in error.

Table 10 Medicaid Eligibility Errors for Active Cases by Stratum by Number of Errors and Dollars in Error

Stratum	Number of Errors	Percentage of Errors	Dollars in Error	Percentage of Dollars in Error
New Applications	7	33.33%	$192.31	2.92%
Redeterminations	4	19.05%	$2,319.00	35.21%
All Other Active Cases	10	47.62%	$4,075.02	61.87%
Active Cases	**21**	**100.00%**	**$6,586.33**	**100.00%**

Conclusion

Iowa has a low overall Medicaid error rate compared to the 17 states measured in 2008. Each of the Medicaid component error rates for Iowa is lower than the corresponding national component error rate. Iowa's Medicaid eligibility error rate is half the national Medicaid eligibility error rate and Iowa has no Medicaid managed care errors. Iowa should target insufficient documentation and medically unnecessary service errors as well as eligibility cases that are not eligible to reduce its overall error rate.